

## **DISCUSSION POINTS**

### **MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES CONSOLIDATION WAIVER PROGRAM**

**Background:** The third waiver renewal request for the continued operation of the Medi-Cal Specialty Mental Health Services Consolidation Waiver Program was approved by the Centers for Medicare and Medicaid Services (CMS) on April 24, 2003. The fourth waiver renewal request is under development and will be submitted to CMS no later than January 26, 2005.

#### **What is a waiver?**

### **1915(b) FREEDOM OF CHOICE WAIVERS**

**PURPOSE:** Section 1915(b) of the Social Security Act provides "the Secretary (of *federal Department of Health and Human Services*) may . . . **waive** such requirements of section 1902 (other than subsection (s) [sic] (other than sections 1902(a)(15), 1902(bb) and 1902(a)(10)(A) insofar as it requires provision of care and services described in section 1905(a)(2)(C)) as may be necessary" to allow states to operate 1915(b) waiver programs. (Section 1902 describes the requirements that states must include in their Medicaid state plans; sections 1902(a)(15) and 1902(bb) establish the rate process for rural health clinics (RHCs) and federally qualified health centers (FQHCs), section 1902(a)(10)(A) requires that services be comparable among specific categories of beneficiaries, and section 1905(a)(2)(B) and (C) defines services in RHCs and FQHCs.)

### **FEATURES**

1. GENERAL FEATURES: States generally use these waivers to set up managed care arrangements and most often request waivers of section 1902 requirements for **statewideness, comparability of services, and freedom of choice**. These waivers are often called "Freedom of Choice Waivers." Section 1915(b) waivers are limited in that they apply to existing Medicaid eligible beneficiaries; authority under this waiver cannot be used for eligibility expansions. There are four 1915(b) types of Freedom of Choice Waivers:

- (b)(1) is used for programs that require beneficiaries to enroll in primary care or specialty physician-based managed care plans
- (b)(2) is used when the state uses a "central broker" to enroll beneficiaries in plans
- (b)(3) is used when the state uses cost savings to provide additional services
- (b)(4) is used when the other types do not apply and the state requires beneficiaries to obtain services from specific providers or plans

#### **2. WHY A 1915(b) WAIVER?**

In order to:

\*Mandatorily enroll beneficiaries into managed care plans, although states have the option.

\*Create a "carveout" delivery system for specialty care-for example: Managed Behavioral Health Care Plan

\*Create programs that are not available statewide

\*Provide an enhanced service package--this allows states to provide additional services to Medicaid beneficiaries via savings from managed care product

3. 1915(b) WAIVERS ARE LIMITED IN SCOPE: States cannot use them to serve beneficiaries beyond Medicaid State Plan Eligibility

4. PROCESS OF APPLICATION: The State submits a waiver request to CMS. CMS has 90 days to approve or disapprove the waiver request or to request additional information. If additional information is requested, the State must provide the additional information. Once the additional information is received, CMS has 90 days to approve or disapprove the waiver request. CMS approves the waiver programs for two year periods. The waiver programs can be renewed on an ongoing basis if the State applies to CMS. The approval process for a waiver renewal request works in the same way as the approval of the initial request.

5. REQUIREMENTS: A 1915(b) waiver program cannot negatively impact beneficiary access, quality of care of services, and must be cost effective.

6. EVALUATION/REPORTING REQUIREMENTS: An independent assessment must be conducted for the first two waiver periods. CMS may require additional assessments if appropriate. Independent assessments of the Medi-Cal Specialty Mental Health Services Consolidation waiver program were conducted in 1997, 1999 and 2002. The additional assessment was requested because of the major change in the waiver program in 1997 from covering hospital services only between 1995 and 1997 and the phase-in of all specialty mental health services between November 1997 and July 1998.

**Public Process:** DMH committed to conduct a public process during the course of waiver renewals. The previous second and third waiver renewals have not differed substantially from the initial waiver request. This fourth waiver renewal request is in a new pre-print format issued by CMS for 1915(b) waiver renewals and includes significant changes addressing new federal requirements and new areas of interest by CMS. A draft copy of the waiver renewal request will be provided at the public hearing. The procedures for cost effectiveness part of the waiver renewal have changed; but due to the technical nature of the change information will not be available at the time of this public hearing. Information will be disseminated by DMH as soon as it is available.

**Current timelines:**

- ❑ August 31, 2004 Waiver draft to DHS for review
- ❑ October 22, 2004 Tribal input due
- ❑ December 21, 2004 CMS receives waiver renewal request for review

- ❑ January 21, 2005 CMS submits Additional Request for Information (AIR) to DHS and DMH
- ❑ March 29, 2005 AIR responses submitted to CMS
- ❑ April 2005 CMS approves the waiver renewal application

**KEY AREAS OF INTEREST INCLUDE THE FOLLOWING:**

- ❑ Previous waiver renewals have been contingent on the State providing a justification for the continuation of the sole source exemption that allows DMH to contract exclusively with counties to be the mental health plans (MHPs). CMS has indicated informally that the waiver renewal sole source exemption may not continue to be necessary based on a change in federal guidelines for procurement. The State will be seeking formal confirmation of the applicability of the change to the waiver program.
- ❑ New Sections B and C of the waiver renewal request require integration of on-site compliance reviews, technical assistance provided to MHPs, ombudsman office, External Quality Review findings, and data analysis to evaluate the overall effectiveness of the system. See below for more information on these sections.
- ❑ Federal requirements which require the State to consider new ways of performing existing activities are integrated into the waiver renewal request, including:
  - Information Requirements
  - Beneficiary Rights and Protections
  - Emergency and Post-Stabilization Services
  - Availability of Services
  - Assurances of Adequate Capacity and Services
  - Authorization of Services, including Expedited Authorizations
  - Provider Selection
  - Practice Guidelines
  - Quality Assessment and Performance Improvement Programs
  - External Quality Reviews
  - Health Information Systems
  - Grievance and Appeals Systems, including Expedited Appeals
  - Program Integrity, including Compliance Plans
- ❑ Brining San Mateo and Solano County MHPs under the waiver program to simplify administrative requirements. Between 1995 and the present, the Medi-Cal Specialty Mental Health Services Consolidation waiver program has not included San Mateo and Solano Counties. The San Mateo County MHP has operated under a separate 1915(b) waiver, titled the Medi-Cal Mental Health Care Field Test (San Mateo County). The Solano County MHP has being operated under a separate 1915(b) waiver for the Partnership Healthplan of California, a COHS. The fourth waiver renewal request will include San Mateo and Solano Counties; thus making the geographic area of the waiver statewide.

## **NEW PRE-PRINT WAIVER STRUCTURE:**

### **Section B: Monitoring Plan**

Per section 1915(b) of the Act and 42 CFR 431.55, states must assure that 1915(b) waiver programs do not substantially impair access to services of adequate quality where medically necessary. To assure this, states must actively monitor the major components of their waiver program described in Part I of the waiver preprint:

Program Impact	(Program Integrity, Information to Beneficiaries, Grievance Systems)
Access	(Timely Access, Specialty Capacity, Coordination and Continuity of Care)
Quality	(Coverage and Authorization, Provider Selection, Quality Assessment and Performance Improvement)

For each of the programs authorized under this waiver, this Part identifies how the state will monitor the major areas within Program Impact, Access, and Quality. It acknowledges that a given monitoring strategy may yield information about more than one component of the program.

For instance, consumer surveys may provide data about timely access to services as well as measure ease of understanding of required enrollee information.

As a result, this Part of the waiver preprint is arranged in two sections.

The first is a chart that summarizes the strategies used to monitor the major areas of the waiver.

The second is a detailed description of each strategy.

#### **Specific requirements:**

The Medicaid Managed Care Regulations in 42 CFR Part 438 put forth clear expectations on how access and quality must be assured. Subpart D of the regulation lays out requirements for MCOs and PIHPs, and stipulates they be included in the contract between the state and plan. However, the regulations also make clear that the State itself must actively oversee and ensure plans comply with contract and regulatory requirements (see 42 CFR 438.66, 438.202, and 438.726). The state must have a quality strategy in which certain monitoring strategies are required: network adequacy assurances, performance measures, review of MHP programs, and annual external quality review. States may also identify additional monitoring strategies they deem most appropriate for their programs.

For the SMHS waiver program, the State must check the applicable monitoring strategies in the chart and may attach and reference sections of their quality strategy to provide details. If the quality strategy does not provide the level of detail required

below, (e.g. frequency of monitoring or responsible personnel), the state may still attach the quality strategy, but must supplement it to be sure all the required detail is provided.

## **I. Summary chart**

The State must use the summary chart to summarize the strategies used to monitor major areas of the waiver program.

## **II. Monitoring Strategies**

DMH must check each of the monitoring strategies or functions below used by the state. A number of common strategies are listed in the pre-print and DMH will identify any others it uses. If federal regulations require a given strategy, this is indicated just after the name of the strategy. If the state does not use a required strategy, it must explain why.

For each strategy, the DMH must provide the following information:

- Applicable programs (if this waiver authorizes more than one type of managed care program)
- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of strategy
- Frequency of use
- How it yields information about the area(s) being monitored

## **Section C: Monitoring Results**

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State's Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on programs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

**X** This is a renewal request. The State provides below the results of monitoring strategies conducted during the previous waiver.

For each of the strategies checked in Section B of the previous waiver request, the State should:

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.
- **Summarize the results** or findings of each strategy. CMS may request detailed results as appropriate.
- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action**, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- **Describe system-level program changes**, if any, made as a result of monitoring findings.